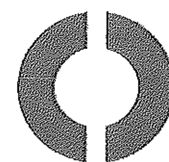
Have a patient struggling to follow up with their care?

Refer them to our Health Home program today!



Community Healthcare Network

Health Homes

What is Health Homes?

Health Homes is a free, voluntary care coordination program that helps promote and facilitate communication among all health care professionals involved in a patient's care. Health Homes helps to make sure that all of a patient's health, mental, and social services needs are met.

How do providers refer patients to Health Homes?

Health Homes clients must be:

- on Medicaid
- have at least two chronic conditions; or one serious mental illness; or HIV

A patient must have documentation of illness when they are referred to Health Homes.
Not sure if your patient qualifies for Health Homes? Find a full list on the back of this sheet.

How can Health Homes help patients? We will:

- Assess and assist with psychosocial needs. This includes helping a patient find housing, entitlements, legal, education and community support services.
- Give patients appointment reminders
- Have staff accompany patients to appointments
- Link patients to mental health and drug abuse services
- Reach out to patient's providers to discuss treatment plans
- Help patients with hospital discharge and planning
- Set up transportation to appointments if needed
- Help patients avoid emergency room visits
- Provide crisis intervention
- Help patients navigate health and social services and link patients to providers
- Include providers in a patient's care plan goals
- Give providers updates on a patient's progress by phone and at appointments

If you want to refer a patient, call us at 1 (855) 246-4422 www.chnnyc.org

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Clinical Indicators

All Participants

- Initial medical screen within 30 days
- Initial mental health screen within 30 days
- Annual medical health visit
- Annual mental health screen
- Subspecialty appointment within 30 days of referral
- Problem List & Medication List – reconciliation at every clinical visit
- Inpatient Admissions – rate of hospitalizations/1000 member months
- Readmissions – number of inpatient admissions within 30 days of discharge
- ED Visits/1000 member months

Yearly Screenings

- Initial medical screen within 30 days
- Initial mental health screen within 30 days
- Annual medical health visit
- Annual mental health screen
- Subspecialty appointment within 30 days of referral
- Problem List & Medication List – reconciliation at every clinical visit

Chronic Disease - Medical

Asthma
- Percent of members with persistent asthma who had dispensing events to cover 50% and 75% of the treatment period

Cardiovascular Disease
- Percent of members receiving beta blocker treatment after MI for six months
- LDL – yearly

Diabetes
- HbA1c – yearly
- LDL – yearly

Hypertension
- Percent with blood pressure controlled at ≤140/90
- Monitoring for patients on ACE/ARB – potassium & GFR yearly

HIV
- CD4 & VL monitoring – every 3 months
- Syphilis screening – yearly
- Provider visit – every six months

Obesity
- Nutrition Referral within 30 days of diagnosis

Mental Health

- Follow up visits within 7 days and 30 days after discharge for mental illness
- Retention – 5 clinical visits within 90 after discharge for mental illness
- Follow up visits within 7 days, 30 days, and 90 days after discharge for Alcohol and Chemical Dependency Detoxification

Bipolar Disorder
- At least 80% proportion of days covered of a treatment drug during the measurement period if on prescription medication

Depression
- Percent remaining on anti-depressant medication for at least 6 months

Schizophrenia
- At least 80% proportion of days covered of a treatment drug during the measurement period

Substance Abuse
- *Initiation* – Initial clinical encounter within 14 days of diagnosis
- *Engagement* – Initial clinical encounter and 2 additional clinical encounters within 30 days of diagnosis

About Community Healthcare Network

www.chnnyc.org

CHN is a not-for-profit organization providing access to affordable, culturally-competent and comprehensive community-based primary care, dental, nutrition, mental health and social services for diverse populations in underserved communities throughout New York City. CHN serves more than 75,000 individuals a year who would otherwise have little or no access to critical health care. CHN is composed of eleven Federally Qualified Health Centers (FQHCs), NCQA designated Level 3 Patient Centered Medical Homes (PCMH) and a mobile health unit.